STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING _____ B. WING _____	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey and Complaint investigation #28214 were completd at Life Care Center of Crossville on June 27 through 29, 2011. No deficiencies were cited related to Complaint #28214 under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow physicians orders for two (#2, #13) of twenty-four residents reviewed. The findings included: Resident #2 was admitted to the facility on November 26, 2008, with diagnoses including Failure to Thrive, Senile Dementia, Hypertension, and Depression. Review of the Minimum Data Set (MDS) dated May 3, 2011, revealed the resident had severe cognitive impairment, was non-ambulatory, and dependent on staff for personal hygiene and bathing activities. Review of the resident's Fall Risk Evaluation dated May 4, 2011, revealed the resident was at risk for falls. Review of the resident's care plan dated November 15, 2010, revealed the resident used the wheelchair most of the day for locomotion.	F 281	F - 281 A. What corrective action(s) will be accomplished for those residents found to have been affected: On 6/28/11, CNA applied hipsters and cushion in wheelchair for resident #2. On same date, ADON applied heel protectors and floated heels for resident #13. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Audit of residents was completed 6/28/11 by RN unit managers to ensure compliance with physician orders for pressure relieving products in bed/chair/other. Corrections were made as needed.	8/8/2011 8/8/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 7/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 Review of the resident's care plan for skin integrity dated November 15, 2010, revealed the resident had potential for skin breakdown and "...Place pressure relieving product on bed/chair/other..." Review of the Physician's Orders (the monthly recapitulation orders) dated June 1 through June 30, 2011, revealed "...Hipsters (hip pads) to be worn at all times..." and "...Place in w/c (wheelchair) with cushion when out of bed..." Observation of the resident on June 27, 2011, at 1:15 p.m., and June 28, 2011, at 2:45 p.m., revealed the resident up in the wheelchair without hipsters and without the use of the cushion in the wheelchair. Interview with the Licensed Practical Nurse (LPN) #2 on June 28, 2011, at 2:45 p.m., in the resident's room confirmed the physician's orders had not been followed with regard to the use of the cushion in the wheelchair and hipsters. Resident #13 was readmitted to the facility on March 3, 2011, with diagnoses including Aftercare Traumatic Fracture Hip, Mental Disorder, Alzheimer's disease, Psychosis, Hypertension, Depression Disorder, Cellulitis Arm, and Adult Failure to thrive. Medical record review of the Minimum Data Set dated May 30, 2011, revealed the resident had difficulty with long and short term memory, severe cognitive impairment, was non-ambulatory, and required assistance with all activities of daily living.	F 281	C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? Director of Nursing to complete education with RN/LPN/CNA associates by 7/21/11 to ensure compliance with physician orders for pressure relieving products in bed/chair/other. Room-to-room observation audit will be completed twice weekly for first month, then weekly for two months by unit managers, MDS nurses, and wound care nurse to ensure compliance with physician orders for pressure relieving products in bed/chair/other. Corrections will be made at time of audit if needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of physician order audits will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/8/2011 8/8/2011

DEPARTMENT OF HEALTH AND HU[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 2 Medical record review of the physician's recapitulation orders dated June 2011 revealed "Heel protectors on while in bed...Float heels with a pillow at all times." Observation on June 28, 2011, at 9:15 a.m., with the Assistant Director of Nursing (ADON) revealed the resident in bed wearing a leg splint on the right leg and wearing tight fitting socks on both feet which had developed foot drop. Continued observation revealed the resident had two open areas on the top of the 2nd and 3rd toes on the left foot. Continued observation revealed one heel protector lying in the chair at the foot of the resident's bed and the second heel protector was not found in the room. Continued observation revealed the resident's feet were not floating on a pillow. Interview with the ADON on June 28, 2011, at 9:15 a.m., in the resident's room confirmed the physician's orders were not followed.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide nail care for two (#2, #13) of twenty-four residents	F 312	F 312 A. What corrective action(s) will be accomplished for those residents found to have been affected: Finger nails of resident #2 were cut 6/28/11 by CNA and toe nails of resident #13 were cut 6/28/11 by LPN. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? RN Unit Mangers completed audit of all residents' finger and toe nail care 7/12/11. Nails were trimmed if needed.	8/8/2011 8/8/2011

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F 312	Continued From page 3 reviewed. The findings included: Resident #2 was admitted to the facility on November 26, 2008, with diagnoses including Failure to Thrive, Senile Dementia, Hypertension, and Depression. Review of the Minimum Data Set (MDS) dated May 3, 2011, revealed the resident had severe cognitive impairment, was non-ambulatory, and dependent on staff for personal hygiene and bathing activities. Observation of the resident's fingernails on June 27, 2011, at 1:15 p.m., and June 28, 2011, at 7:45 a.m., revealed the resident's fingernails were long. Observation on June 28, 2011, at 10:45 a.m., revealed the resident entered the shower room with a Certified Nurse Assistant to receive a shower. Observation after the resident's shower on June 28, 2011, at 2:45 p.m., revealed the resident's fingernails were long. Interview with the Licensed Practical Nurse (LPN) #2 in the resident's room on June 28, 2011, at 2:45 p.m., confirmed the resident's fingernails were long and needed to be trimmed. Resident #13 was readmitted to the facility on March 3, 2011, with diagnoses including Aftercare Traumatic Fracture Hip, Mental Disorder, Alzheimer's disease, Psychosis, Hypertension, Depression Disorder, Cellulitis Arm, and Adult Failure to thrive. Medical record review of the Minimum Data Set dated May 30, 2011, revealed the resident had	F 312	F 312 Continued C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? Director of Nursing will complete education with CNA associates by 7/21/11 to observe and provide nail care during showers and report any additional nail care needs to licensed nurse. Room-to-room observation audit will be completed twice weekly for first month, then weekly for two months by unit managers, MDS nurses, and wound care nurse to ensure compliance with ADL nail care. Care will be provided at time of audit if needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of nail care audits will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/8/2011 8/8/2011

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F 312	Continued From page 4 difficulty with long and short term memory, severe cognitive impairment, was non-ambulatory, and required assistance with all activities of daily living. Observation on June 28, 2011, at 9:15 a.m., with the Assistant Director of Nursing (ADON) revealed the resident in bed wearing a leg splint on the right leg and wearing tight fitting socks on both feet which had developed foot drop. Continued observation revealed the resident had two open areas on the top of the 2nd and 3rd toes on the left foot. Continued observation revealed the resident's toenails on the left foot were thick, long, and curved under the resident's toes. Interview with the ADON on June 28, 2011, at 9:15 a.m., in the resident's room, confirmed the resident's toenails were thick, long, and had curved under the resident's toes and needed to be trimmed.	F 312		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F 371 A. What corrective action(s) will be accomplished for those residents found to have been affected: A steel fabricating contractor evaluated walk-in refrigerator 7/11/11 for aluminum plates for areas affected by rust. Steel fabrication repairs will be completed 8/8/11. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Dietary Manager will complete education with dietary associates by 7/21/11 to ensure that rusted equipment is reported to supervisor.	8/8/2011 8/8/2011

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F 371	Continued From page 5 Based on observation and interview, the facility failed to maintain the dietary department walk-in refrigerator in proper repair. The findings included: Observation on June 27, 2011, at 8:58 a.m., with the Certified Dietary Manager present revealed the walk-in refrigerator floor was covered with rust. Further observation revealed the rust had penetrated the surface of the metal floor resulting in irregular multiple layers of rusted flooring. Further observation revealed rust had penetrated the metal surface of the door jam, from the refrigerator floor upward, of the walk-in refrigerator. Interview on June 27, 2011, at 8:58 a.m., with the Certified Dietary Manager confirmed the walk-in refrigerator floor was covered with rust. Further interview confirmed the rust had penetrated the surface of the floor covering and the metal surface of the door jam of the walk-in refrigerator.	F 371	F 371 Continued C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? Dietary Manager to complete monthly observation audit for three months of walk-in refrigerator to ensure elimination of rust. Corrections will be made if needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of monthly walk-in refrigerator audits will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/8/2011 8/8/2011
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	F 441 A. What corrective action(s) will be accomplished for those residents found to have been affected: On 6/28/11 nasal cannula was changed and stored in bags by CNA for residents #11, #17, and #18. Fan for resident #24 was turned off, then removed from room by housekeeping associates, cleaned, and returned to resident.	8/8/2011

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F 441	Continued From page 6 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, policy review, and interview, the facility failed to maintain nasal cannula storage in a manner to prevent infection for three residents (#11, #17, #18); and failed to maintain a clean fan in a manner to prevent infection for one resident (#24) of twenty-four residents reviewed. The findings included: Resident #11 was admitted to the facility on	F 441	F 441 Continued B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Room-to-room observation audit completed 7/12/11 RN unit managers, MDS nurses, and wound care nurse of residents with oxygen orders to ensure proper storage of nasal cannula. Corrections will be made if needed. Room-to-room observation audit completed 7/15/11 by Director of Environmental Services to ensure residents' fans are cleaned. Residents' fans will be cleaned by Housekeeping if needed. C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? Room-to-room observation audit will be completed twice weekly for first month, then weekly for two months by unit managers, MDS nurses, and wound care nurse for residents with oxygen orders to ensure proper storage of nasal cannula. Corrections will be made if needed. Director of Nursing will complete education of RN/LPN/CNA associates by 7/21/11 regarding proper storage of nasal cannula. Room-to-room observation audit will be completed weekly for three months by Director of Environmental Services to ensure that fans used by residents are clean. Director of Environmental Services will complete education of Housekeeping associates by 7/21/11 regarding cleansing of residents' fans.	8/8/2011 8/8/2011

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F 441	Continued From page 7 November 29, 2010, and readmitted on February 10, 2011, with diagnoses including Mental Disorder and Diabetes Mellitus. Observation on June 27, 2011, at 9:20 a.m., and 12:53 p.m., revealed an oxygen concentrator with a coiled nasal cannula stored on the concentrator. Interview with Certified Nurse Aide #2 on June 27, 2011, at 12:53 p.m., in the resident's room confirmed the nasal cannula should be stored in a bag when not in use. Resident #17 was admitted to the facility on January 7, 2010, and readmitted on March 4, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Late Effect Cerebrovascular Accident with Right Hemiparesis, and Anxiety. Observation on June 27, 2011, at 9:30 a.m., revealed the resident in the bed, the oxygen concentrator was in operation, and the nasal cannula was in direct contact with the floor. Interview on June 27, 2011, at 9:30 a.m., with Certified Nurse Aide #1, in the resident's room, confirmed the nasal cannula was to be stored in a bag when not in use. Observation on June 28, 2011, at 1:00 p.m., revealed the resident in bed, both full side rails in the upright position, the oxygen concentrator was in operation, the oxygen tubing was draped over the side rail, and the nasal cannula was in direct contact with the interior surface of the trash can.	F 441	F 441 Continued D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of nasal cannula and fan audits will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/8/2011

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F 441	Continued From page 8	F 441		

Resident #18 was admitted to the facility on April 27, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Sleep Apnea, Congestive Heart Failure, and Diabetes Mellitus.

Observation on June 28, 2011, at 2:35 p.m., revealed the resident in the bed, the oxygen concentrator was in operation, and the nasal cannula was in direct contact with the floor.

Interview with Licensed Practical Nurse #1 on June 28, 2011, at 2:38 p.m., in the resident's room, confirmed the nasal cannula was to be stored in a bag when not in use.

Review of facility policy Oxygen Therapy-Mask & (and) Nasal Cannual revealed "...Procedure...4. When masks and cannulas are not in use, store in a plastic bag..."

Interview with the administrator in the conference room, on June 28, 2011, at 4:00 p.m., confirmed the facility failed to follow the policy to store nasal cannulas in a bag when not in use.

Resident #24 was admitted to the facility on April 6, 2010, and readmitted on April 4, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Acute Bronchitis, Asthma, Depend Supplement Oxygen, and Depressive Disorder.

Observation on June 28, 2011, at 2:35 p.m., revealed the resident in the bed, the oxygen concentrator was in operation, the nasal cannula

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F 441	Continued From page 9 was placed on the resident, and a table top fan was blowing directly onto the resident. Further observation revealed the fan grate had an accumulation of hanging debris. After stopping the fan, observation revealed the fan blades were covered with an accumulation of blackened debris. Interview with the resident, at 2:35 p.m., on June 28, 2011, in the resident's room, confirmed the fan was the resident's personal property and it (fan) "was dirty." Interview with the administrator, on June 28, 2011, at 2:37 p.m., in the resident's room, confirmed the fan grate and blades were not clean.	F 441		